Manchester City Council
Report for Resolution

Report to: Children and Young People Scrutiny Committee – 7 November 2017

Subject: Early Years Update

Report of: Director of Education

Summary

This report provides the committee with a summary of the additional 30 hours early education funding for working parents and its implications for the city and a review of the impact of Stages 3,4 and 5 of the Early Years Delivery Model.

Recommendations

Members are asked to note the contents of the report.

Wards Affected: All

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Background documents (available for public inspection):

None

1.0 Introduction

1.1 This report provides the committee with a summary of the additional 15 hours early education funding for working parents and its implications for the city and a review of the impact of Stages 3, 4 and 5 of the Early Years Delivery Model.

2.0 The introduction of 30 hours free childcare for working parents

2.1 The Government's Free Early Education Entitlement policy provides funding for 15 hours of early education for a targeted group of two year olds and universal provision of funding for 15 hours for the early education of three and four year olds.

2.2 The Childcare Act 2016 introduced an additional entitlement of a further 15 hours of childcare support for working parents. The Act extended the entitlement to 30 hours free childcare over 38 weeks of the year for three and four year old children in families where all parents are working.

2.3 As with the current entitlement for two year olds and the 15 hour entitlement for all 3 year olds, the extension to 30 hours for those working parents who are eligible, can be accessed in schools, nursery schools, private, voluntary and independent settings, playgroups and childminders.

3.0 Eligibility criteria for the 30 hours early education funding

3.1 Parents, including single parents, are eligible for the additional hours of funding if they meet the agreed criteria. These include:

- Parent(s) who are in work- or in receipt of sick leave, parental leave or annual leave
- Parent(s) each earning at least the national Minimum Wage or Living Wage for 16 hours a week up to a taxable income of £100,000 (Each parent must have an annual income of less than £100,000 and must be currently earning at least £120 a week.)

3.2 Both parents must be working or be the sole parent working in a lone parent family.

4.0 Accessing the 30 hours

4.1 The way in which the entitlement is accessed depends on the family arrangement and arrangements within the provider school or setting. For example some parents require childcare to fit with their working or training needs. Some settings, such as childminders, offer greater flexibility outside traditional school hours and structures to meet these needs.

4.2 The child's entitlement to the funding for three and four year olds begins in the term following their third birthday. Children born in the period 1st January to 31st March are eligible for funding from the start of term beginning on or following 1st April after the child's third birthday; children born in the period 1st April to 31st

August: the start of term beginning on or following 1st September after the child's third birthday and children born in the period 1st September to 31st December: the start of term beginning on or following 1st January after the child's third birthday.

4.3 Eligible families were able to claim their entitlement to the additional hours of early education from 1st September 2017.

5.0 Checking Eligibility

5.1 To access the offer of additional hours, parents must check their eligibility using the Childcare Choices website https://www.childcarechoices.gov.uk/. If eligibility is confirmed the parents must sign up online to be issued with an 11 digit eligibility code. This code is issued by Her Majesty's Revenue and Customs (HMCR). Parents then give this code to their childcare provider who will use it to claim the funding for the place they provide. The additional hours then start in the term following the child's third birthday. For example parents need to apply by 31st December 2017 to access extra hours starting in January 2018. The 11 digit code must be reconfirmed each term. The funding per place for the additional hours is approximately £830 per term.

6.0 Uptake and eligibility in Manchester

6.1 An estimated 3,500 three and four year olds in Manchester are eligible for an additional 15 hours childcare from September 2017. (source: Department for Education 2017) . By 31st August 1,695 eligibility codes had been issued to families by HMRC, representing 48% of the potential eligible cohort. Take up of the eligibility checking process has been slower in Manchester than in other areas. This is likely to reflect the fact that the majority of parents have already been accessing a funded full time equivalent place in a school nursery due to the historical funding arrangements in place in the city. (see para 3.1). A communications campaign has been in place to promote the offer and increase applications.

7.0 Communication and take up of the additional 30 hours

7.1 Communication with parents

7.1.1 Communication to parents about the 30 hours offer has been carried out through a social media campaign including Facebook, Instagram and Twitter messages as well as through Broadcast and e-bulletin messages. In addition throughout August the 30 hour childcare offer was promoted on billboards and other static displays across the City encouraging families to check their eligibility before the Autumn term deadline date of 31st August 2017. This communication campaign continues for the new term.

7.2 Communication with schools and settings

7.2.1 Consultation events were carried out in March 2017 with Schools and PVIs to raise awareness of the 30 hour offer and outline proposed procedures and

timeframes. Both were well attended with approximately 70 delegates at each. These events were followed up in May 2017 with school business manager forums.

7.2.2 There has been regular communication to schools and settings through newsletters, emails and circular letter. Detailed guidance has been sent into schools to enable them to draw down funding, gain access to the headcount portal, support the identification of eligible families and meet timescales for headcount claims. This is because the whole process is new to schools. The headcount portal enables schools and settings to complete their claims.

7.2.3 A number of drop in sessions have provided advice and support to schools using the headcount portal for the first time. The emphasis for the rest of the Autumn term will be on increasing take up and ensuring all schools are engaged in the process to maximise take up from 1st January 2018.

8.0 The implications of the additional funded hours for Manchester

8.1 School

8.1.1 Historically MCC has supported the universal provision of full time equivalent places for three and four year olds in schools in the year before Reception. This has included an additional ten hours of early years education in schools on top of the universal 15 hour entitlement, bringing the entitlement up to a 25 hour full time equivalent place. Since September 2014, following agreement at the Schools Forum, the funding previously allocated for the additional 10 hours of full time early years places, was moved into the Schools Block funding to enable schools to have flexibility about how they use the funds to meet need. The revised arrangement continued to provide the funding to schools through the main school budget for 5-11 year olds, giving individual schools the choice to continue to offer full time nursery places. The majority of Manchester's 132 primary schools therefore still choose to offer a full time nursery class place.

8.1.2 As schools become more aware of the process for accessing parents' eligibility codes and drawing down funding it is likely that rates of take up will improve and that the majority of funded places will continue to be in school nurseries. To date 70 schools have registered to claim childcare funding through the Headcount portal. The additional hours funding is worth up to £2,500 per year per eligible pupil for schools.

8.2 Childcare settings

8.2.1 Although parents overwhelmingly choose to access their full time place in school where this is available, some parents prefer to take up their entitlement in childcare settings. Parents seek places in the private sector because of the flexibility offered by providers. This can better meet the needs of some working parents, particularly where a child is already settled in a setting. To date there has been no evidence that the 30 hours legislation has led to significantly more parents choosing to access their entitlement in the private sector.

8.2.2 Settings are very familiar with the claims process as they have been using a similar system to draw down funding for places for two year olds eligible for the childcare offer. The funding for the additional hours for three and four year olds will be a further funding stream for private providers.

8.3 Implications for the City

8.3.1 Take up of this funding for 30 hours is reported in the January Census and is likely to influence Manchester's budget settlement for additional childcare in 2017/18. It is important to the City to demonstrate the appropriate level of take up to avoid being underfunded in future financial years.

9.0 Next Steps:

- Continue to share good practice via the Knowledge Hub, an online forum used by LAs within Greater Manchester
- Continue to promote the entitlement to schools, settings and parents to increase take up to maximise funding available in the City.

10.0 The Early Years Delivery Model

10.1 Health Visitor performance using Ages and Stages Questionnaire (ASQ3)

10.1.1 The Early Years Delivery Model (EYDM) is an integrated pathway for all children from pre-birth to 5 years of age in partnership with health care and early years professionals. The model supports the delivery of the Sure Start Core Purpose which has at its heart improving outcomes for young children and their families and reducing inequalities in: child development and school readiness; parenting aspirations and parenting skills; and child and family health and life chances.

10.1.2 An 8 stage model based on assessment at key points was developed across Greater Manchester in line with the national expansion of Health Visitors. The 8 stage model largely aligns to the requirements of the Healthy Child Programme (HCP) and has a requirement to use the Ages and Stages Questionnaire 3 (ASQ3) as the main assessment tool.

10.1.3 The first five stages of the eight stage assessment model are in place across the city

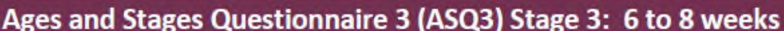
- Stage 1 assessment; Health Visitor antenatal visit from 28 weeks.
- Stage 2 assessment ; new birth visit at 10- 14 days
- Stage 3 assessment ; two month HV visits making use of the evidence based Ages and Stages Questionnaire 3 (ASQ3) and a Maternal Mental Health Assessment
- Stage 4 assessment ; nine months assessment offered by booked appointments and making use of the ASQ3
- Stage 5 assessment; 2 year review offered by booked appointments and making use of the ASQ3.

10.1.4 This report focuses on the performance of assessment stages 3,4 and 5 making use of the ASQ3 assessment and the findings of these assessments.

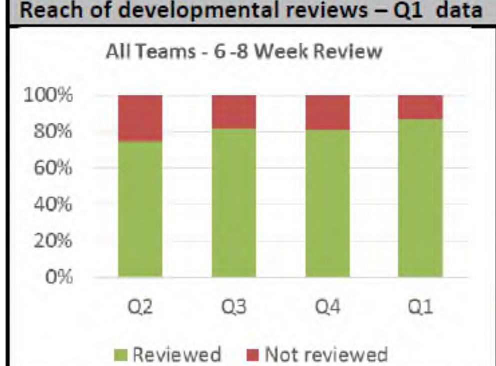
Appendix A contains the full report of the impact of the Early Years Delivery Model to date.

10.2 6-8 weeks

10.2.1 The table below outlines the reach of the developmental review at 6-8 weeks and the proportions of children developing typically or requiring targeted intervention.

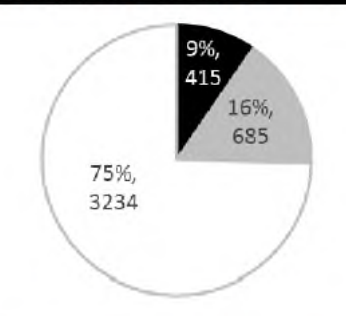


Reach of developmental reviews – Q1 data



- Visit to every baby between the age of 6-8wks to complete an Ages and Stages Questionnaire (ASQ) to assess development and identify needs.
- This additional GM contact was introduced across all teams from April 2015. It is completed as a Home Visit and is often but not always undertaken at the same visit as the Maternal Mental Health.
- **Performance in Q1 is 87% an increase from 81% in Q4.**

ASQ developmental outcomes at 6-8 weeks Q1 data (01/07/16 - 30/06/17)



The ASQ3 is an evidence based assessment completed by parents and supported by professionals. Results are scored and categorised as falling within black, grey or white areas for 5 aspects of learning. Children whose scores fall within the white area are considered to be developing typically. Grey indicates that development requires targeted attention and black indicates that further assessment and specialist attention is required. Children are categorised by their highest level of need in any area of learning. Of the children involved in the 12 months up to the end of Q1 it is estimated that a**t 6-8 weeks 75% of children show typical development in all areas of learning**. 16% require targeted support and 9% specialist attention.

Developmental outcome by area of learning/domain Q1 data

Communication	Gross Motor	Fine Motor	Problem Solving	Personal Social
6% / 2% / 91%	4% / 5% / 91%	1% / 3% / 96%	6% / 2% / 92%	9% / 2% / 89%

The ASQ assesses children against the five areas of learning above; the charts above demonstrate the percentage of children scoring in the white, grey and black for each area of learning. As in the previous section white indicates developing typically, grey indicates targeted activity required and black indicates specialist attention required.

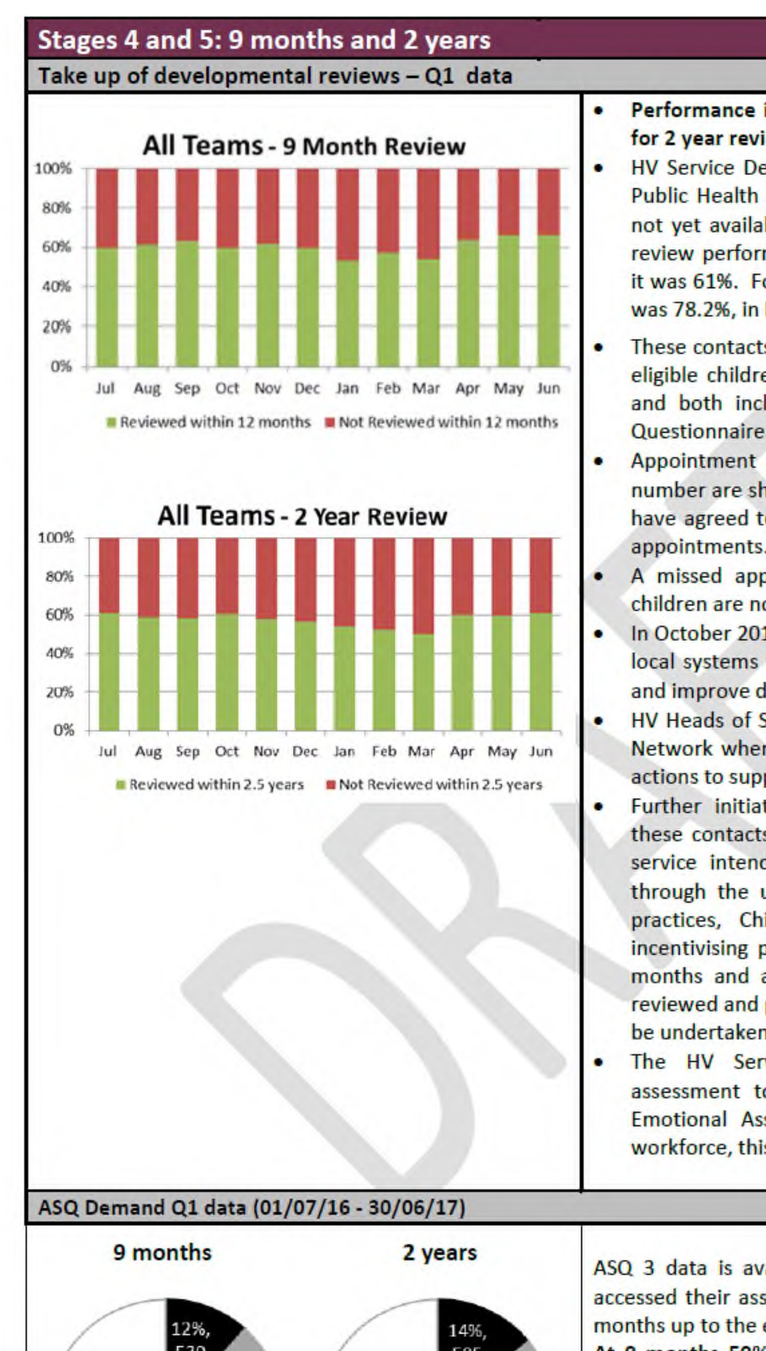
The diagram above indicates that at 6-8 weeks the **need for support or intervention is lowest for fine motor skills** with 96% of children showing expected levels of development, 1% of children being categorised as in the black area indicating a need for specialist attention and 3% categorised as grey indicating targeted attention. **Need for support is greatest for personal social development** where 89% of children are assessed as showing expected levels of development, 2% requiring specialist attention and 9% requiring targeted attention. The ASQ assessment for PSD at this stage includes smiling, crying when hungry and watching own hands.

10.3 Developmental reviews at 9 months and 2 years

10.3.1 The table below outlines the reach of the developmental reviews 9 months and 2 years and the proportions of children developing typically or requiring targeted intervention. Unlike the 6-8 week assessment which takes place in the family home, this review is usually booked by appointment and takes place in clinics or other settings such as Children's Centres.

Stages 4 and 5: 9 months and 2 years

Take up of developmental reviews – Q1 data



- **Performance in Q1 is 65% for 9 month reviews and 60% for 2 year reviews.**
- HV Service Delivery Metrics for England are published by Public Health England on a quarterly basis, Q4 and Q1 is not yet available, Q3 is the most recent. In Q3, 9 month review performance in England was 74.8%, in Manchester it was 61%. For 2 year reviews Q3 performance in England was 78.2%, in Manchester it was 59%.
- These contacts are delivered by booked appointment to all eligible children (100% offer), generally in clinical settings and both include the completion of an Ages & Stages Questionnaire.
- Appointment schedules including the known telephone number are shared with Early Years Outreach workers who have agreed to contact families to remind them to attend appointments.
- A missed appointment algorithm is implemented when children are not brought for an assessment.
- In October 2016, data inputting arrangements changed and local systems were introduced in March 17 to strengthen and improve data quality.
- HV Heads of Service attend Greater Manchester HV Leads Network where clinical best practice is discussed and any actions to support improved performance are explored.
- Further initiatives to improve the performance against these contacts will be implemented during 2017-18. The service intends to promote awareness and attendance through the use of information posters displayed in GP practices, Children's Centres, Health Centres and by incentivising parents/carers with a free dental pack for 9 months and a free book pack. The invite letter will be reviewed and pilots of differing service delivery options will be undertaken.
- The HV Service Specification expects an additional assessment to be undertaken at 2yrs; ASQ-Social and Emotional Assessment. Following training for the HV workforce, this will be implemented during 2017-18.

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ASQ Demand Q1 data (01/07/16 - 30/06/17)

9 months

12%, 530
28%, 1290
60%, 2760

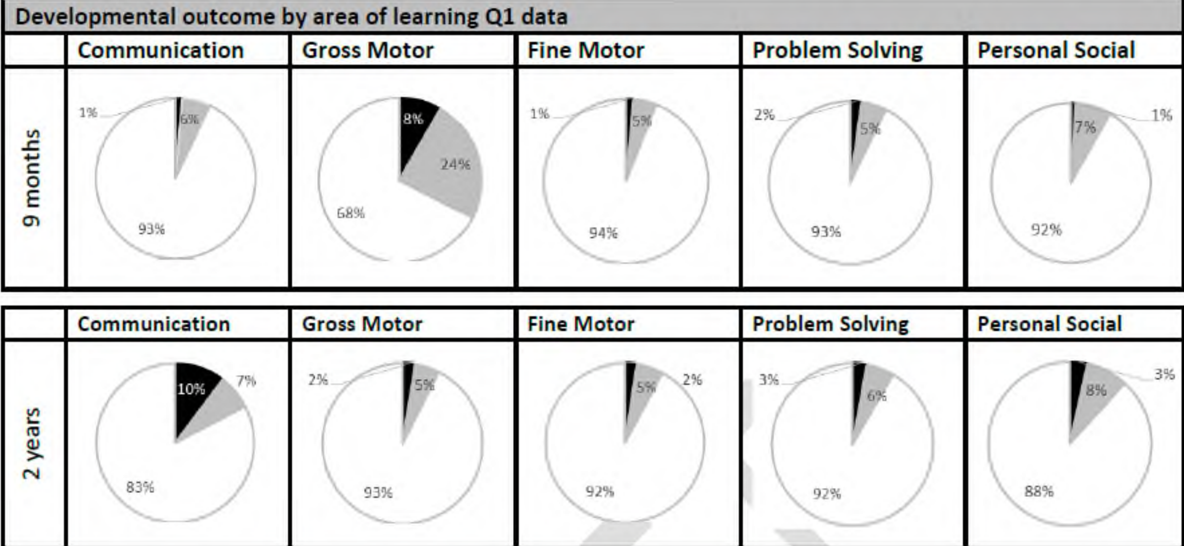
2 years

14%, 585
15%, 625
71%, 3011

ASQ 3 data is available for the percentage of children who accessed their assessment. Of the children involved in the 12 months up to the end of Q1 it is estimated that:

At 9 months 59% of children are developing typically in all areas of learning whilst 29% require targeted attention and 12% specialist attention.

At 2 years 71% of children show typical development in all areas of learning.



The charts above demonstrate the percentage and number of children scoring in the white, grey and black for each area of learning for the 9 month and 2 year reviews.

- **At 9 months gross motor is the area of learning where children show the lowest levels of development** with 68% assessed as showing expected levels of development and 36% of children score in the grey or black area for gross motor skills. At 2 years, however, gross motor needs are much lower with only 7% of children scoring in the black or grey area. Gross motor skills at 9 months include balance, standing and sitting.
- **At 2 years need for support and intervention is greatest for communication** and then personal social areas of learning. Need is greatest for communication with 17% of children scoring in the black or grey area. Notably, communication at 2 years has the highest proportion of children scoring in the black area (10% of children). Communication at this stage of the ASQ3 focuses on items such as pointing and identifying, use of 2 and 3 word phrases and following a simple instruction.
- For personal and social development 11% children require additional support. At 24 months the assessment includes copying activities, eating with a fork and reference to him/herself as 'I'.

Please note that this data does not necessarily show progression between 9 months and 2 years, instead it demonstrates different needs in the present population at different stages. The ASQ data is a snapshot of ASQ assessments in 2016/17, therefore each stage comprises a different cohort of children; data does not show the progression of the same group of children through the stages.

11.0 Next Steps:

11.1 Action is being taken to improve the take up of the developmental review at 9 months and 2 years. This review is carried out by health visitors and parents attend by appointment. The free dental and book packs will be integrated in to the assessment and linked to the Personal Social and Communication areas of development. In addition pilot areas have been selected to trial home visits for these checks in some areas from November 2017. The good practice from health visitor teams achieving high rates of engagement is being shared and a communications campaign is underway. This will raise awareness about the importance of the developmental checks at 9 months and 2 years.

11.2 Targeted interventions to support parenting skills and speech and language development for children and families identified through the use of the ASQ3 assessment continue with increasing numbers of children and families accessing these interventions (see Appendix A).Improving outcomes for communication and personal and social development is central to enabling children to have the best start.

12.0 School Readiness

12.1 Outcomes at the end of the Early Years Foundation Stage (EYFS) provide a key indicator of school readiness at the age of 5 years. Since 2013 outcomes in Manchester have improved by 19% with 66% children now achieving the Good Level of Development (GLD) at the end of the EYFS. However the difference between outcomes in Manchester and those nationally remains at 5%. The provisional national average for the GLD is now 71% indicating that although Manchester is improving at the same rate as nationally, the gap in outcomes remains the same.

12.2 Improving school readiness outcomes is a priority in getting children off to the best start in life. Schools are universal providers that see most children most of the time and as such, schools have a critical role to play in leading and influencing the strategy to ensure children in the city are school ready.

13.0 Conclusion and Next Steps

13.1 The City continues to make progress in implementing the Early Years offer, ensuring access for families to affordable, accessible, quality childcare provision and providing integrated working with health partners through the roll out of the EYDM.

13.2 To further secure this offer the next steps include:

- maximise take up of the additional 30 hours childcare funding for working parents
- improve take up of the 9 month and 2 year development checks
- continue to strengthen the integrated working between health partners and early years practitioners
- work strategically with partners to continue to improve school readiness
- develop school leadership of school readiness in a neighbourhood area

Early Years Delivery Model Q1 2017-18

The dashboard provides a summary of performance and outcomes for the Early Years Delivery Model. The Early Years Delivery Model (EYDM) is an integrated pathway for all children from pre-birth to 5 years of age in partnership with health care and early years professionals. Data relates to the 12 months prior to the end of Q1 2017-18 (01/07/2016-30/06/2017) unless otherwise stated.

Ages and Stages Questionnaire 3 (ASQ3) Stage 3: 6 to 8 weeks

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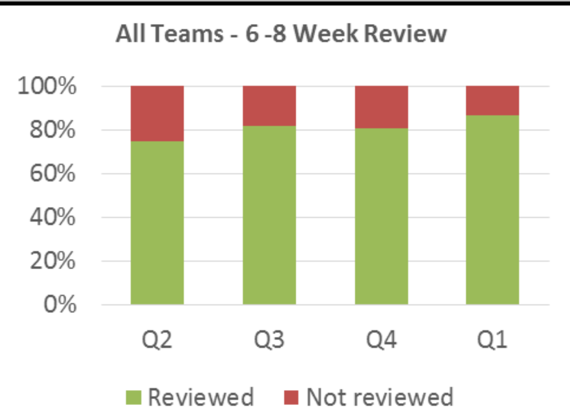

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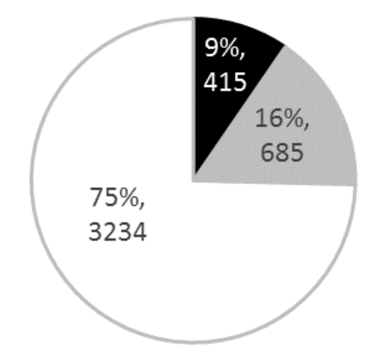

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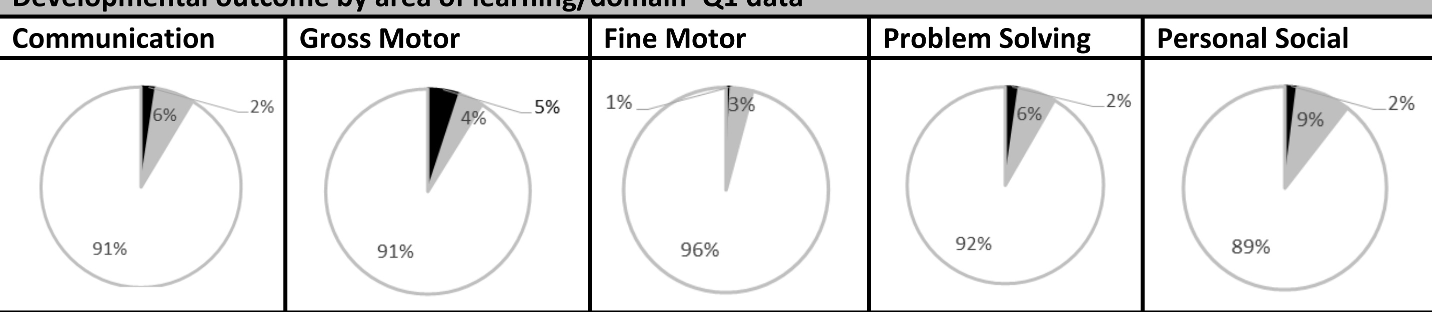

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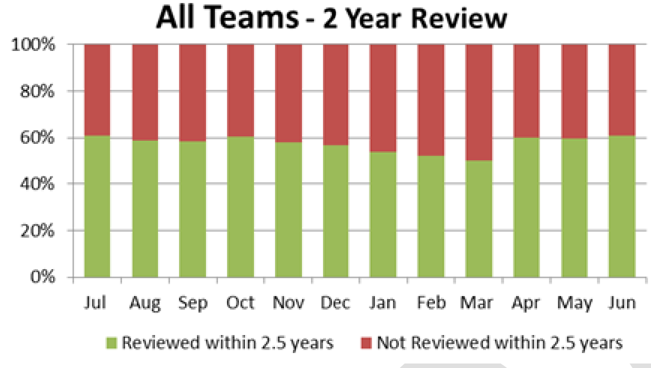

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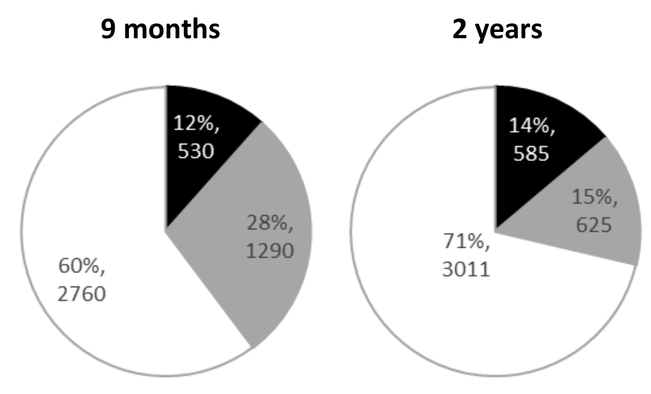

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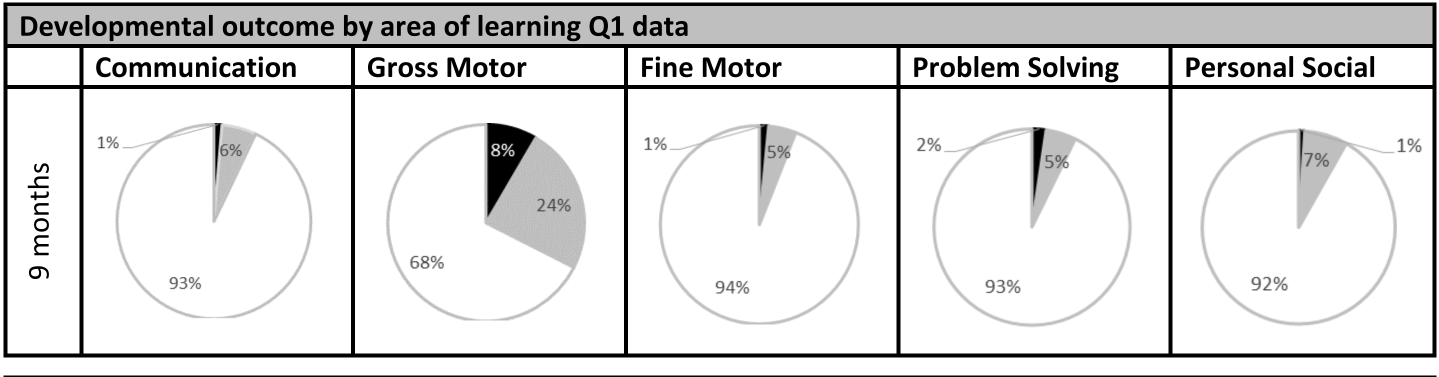

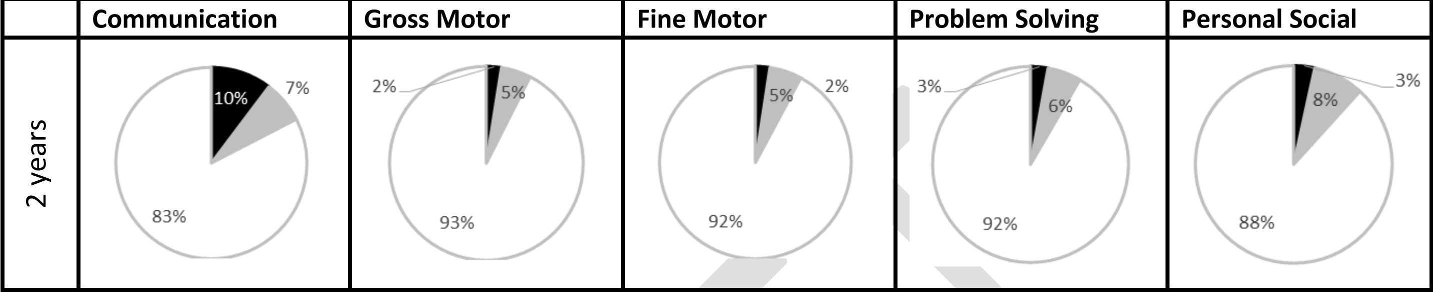

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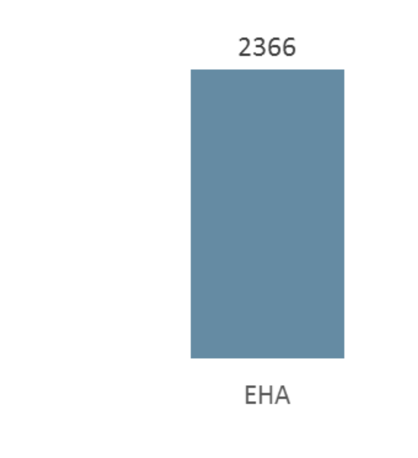
Interventions

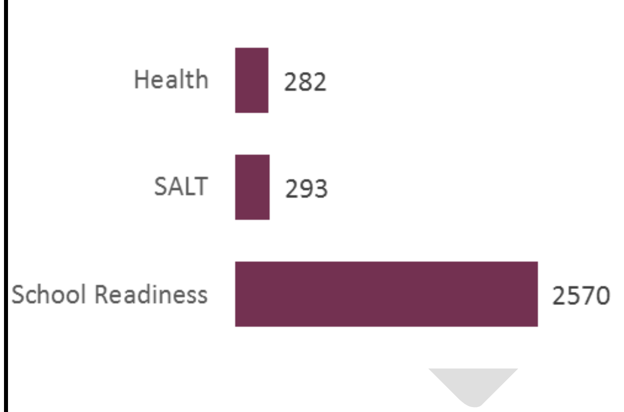
This sections looks at the targeted interventions within the EYDM aimed at addressing the developmental need identified. All children entering targeted intervention in the reporting period are included regardless of whether they were born before or after the implementation of the EYDM. Included is information on the nature of the intervention, the volume of families flowing into intervention, the proportion receiving a complete intervention and the impact of intervention.

Requests for support and intervention



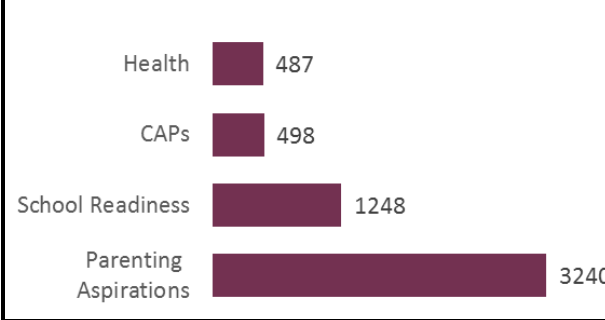
The chart shows the total number of requests for additional support and intervention completed in the EYDM between April 2015 and the end of June 2017 for children who remain under 5 at the end of the reporting period. From September 2016 these requests have been recorded using an Early Help Assessment. As the vast majority of children attend a full time nursery place in a Manchester school from the term after they are three, these figures refer to families with children who are three or under. The population estimate for under 3s is 23,713 *(ONS MYE 2016)* making the **estimate for the percentage of children aged 3 and under for whom additional support has been requested is 10%.**

Reasons for requests for support and intervention - Child



The most frequent child reason for additional support and intervention with Sure Start outreach worker involvement relates to school readiness followed by SaLT and then health and life chances. School readiness interventions include referrals to stay play and learn sessions, targeted 2s and support with nursery or school applications. Health and life chances interventions include missed immunisations, SEN and developmental reviews. The most frequent need identified is overwhelmingly for stay play and learn sessions followed by establishing routines. Speech and Language Therapy (SaLT) refers to SaLT referrals made by the outreach worker for children with a request for support and intervention open at some point in the reporting period.

Reasons for requests for support and intervention – Adult



The most frequent reason for requests for support and intervention relating to adults relates to parenting aspirations followed by school readiness, then CAPs and finally health and life chances. Parenting aspiration interventions include housing, financial, ESOL, employment and training support. School Readiness interventions relate to parental isolation. Health and life chances interventions include substance misuse support and mental health services. The most frequent need identified was isolation followed by housing and then financial support.

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SaLT – Speech and Language Therapy

The Early Years Communication and Language pathway supports language development for young children at risk of language delay. It forms part of the Early Years Delivery Model in Manchester and reflects the Greater Manchester strategy. Evidence confirms that the risks associated with language difficulties can be mitigated by early identification and intervention. Children whose language difficulties are resolved by 5 ½ years are more likely to go on to develop good reading and spelling skills and keep pace with peers, achieving on a par with children without a history of language disorder by the end of schooling (Conti-Ramsden, 2009). The Language pathway is central to improving school readiness so that communication and language in Manchester is at least in line with the national average. Currently, 75% of children in Manchester achieve at least expected levels of development across all learning goals in the communication and language area of learning; this is lower than the England average which is 81.6% (2016 EYFS results).

Children identified as having language difficulties can generally be categorised into two groups:

i. the majority have *transient needs* and with the right kind of support and conditions this group will make good progress towards catching up
ii. the minority have *persistent difficulties*; children who have language needs as a result of another condition such as autism, hearing impairment or a learning disability

Workforce development

Coordinated community wide strategies to develop the skills of the children's workforce and empower parents to give their young children the best start in life can improve language skills across the community. Workforce development therefore forms a key part of the strategy developed within the EYDM and supports children with transient needs. A rolling programme of training, covering universal and enhanced level of communication knowledge and skills has been developed. This programme is available to early years practitioners, health professionals and volunteers and is integral to the overall implementation and success of the Early Years Communication and Language Pathway**. The total number of practitioners trained to date is 1677.** This supports early identification of increased numbers of children with speech, language and communication needs and use of the most appropriate strategies to develop their language skills.

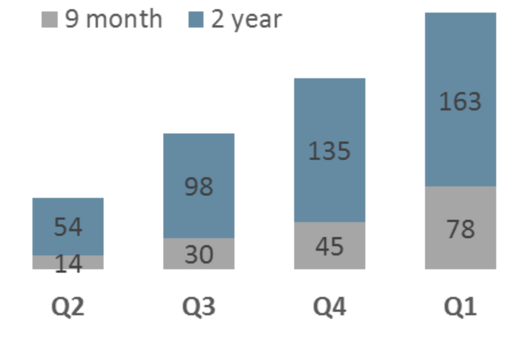
The completion of WellComm Screens

The Communication and Language pathway includes delivery of a standardised language screening tool known as WellComm, which is utilised once an initial concern has been identified. The screen is undertaken by a range of practitioners who have received the required training. The potential outcomes of the tool are:

Red	Referral to specialist speech and language therapy service
Amber	Access to language activities within the Communication and Language pathway
Green	No support required

SaLT interventions - The WellComm Tool

Acculative number of Wellcomms completed by Health Team (9 month and 2 year reviews) in the last 12 months



Health Visitors deliver the Ages and Stages Questionnaire (ASQ) at 9 months and 2 years as part of the Healthy Child Programme. If the ASQ indicates a grey category score for communication the children should subsequently be further assessed via WellComm (for children under 12 months of age an ASQ result of both black and grey would require a WellComm). The ASQ is one pathway which can result in the need for a WellComm screen.

In the 12 months up to the end of Q1 (01/07/16-30/06/17) 241 WellComm screens have been completed, 78 for 9 month olds and 163 for 2 year olds. In **Q1 33% of 2 year olds and 25% of 9 month olds identified through the ASQ for a WellComm screen have a screen attributed to their ASQ,** work is underway to ensure the WellComms can be attributed to the ASQ.

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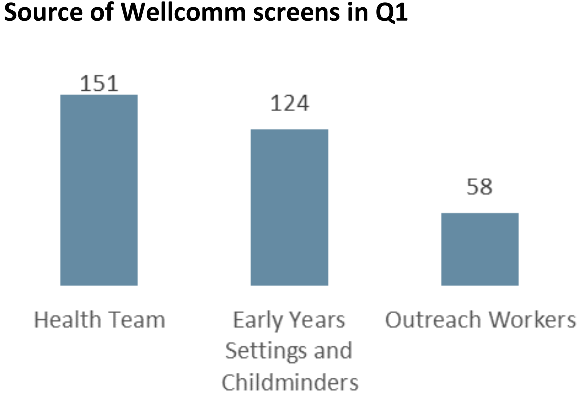
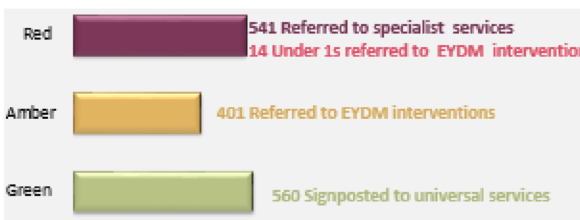
Source of Wellcomm screens in Q1



Demand for WellComm screens can also be identified through other sources these may include early years settings and child minders, Children's Centre outreach workers and wider health team services as well as the 9 month and 2 year reviews. The chart on the left illustrates the source of all WellComm screens in Q1. In total 333 screens were completed in Q1, with 45% completed by the health team.

Wellcomm screening results (all sources)



The chart on the left shows all WellComm screening outcomes collected in the 12 months up to the end of Q1 and illustrates that **from 1478 children screened 401 children scored amber on the WellComm screen and 14 under 1s scored red (28% in total) and therefore should be referred for EYDM intervention.** Data sharing processes between settings/Children's Centres and SaLT are still being established therefore not all screening information is currently available and this area of work is being developed.

Recent analysis of gender from Q3 to Q1 (September 2016 to June 2017) indicates that **boys accounted for 63% of WellComm assessment, 66% of referrals to specialist services and 63% of referrals to EYDM interventions.** The need for communication and language support is therefore predominately with boys

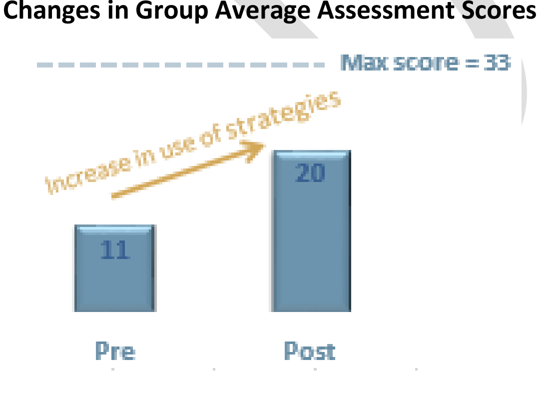
Intervention

53%
40%
7%
Completed
Not yet completed
Refused

In the 12 months leading up to the end of Q1 74% of children identified for Wellcomm activities have been referred. Of the 74% of children referred for Wellcomm activities, 53% have completed intervention, 7% have refused, and 40% have not yet completed.

Impact of EYDM intervention - PCI group

Changes in Group Average Assessment Scores



In addition to Wellcomm activities, parents are given the opportunity to attend Parent Child Interaction (PCI) groups to increase their understanding of language development and communication strategies which support their child's communication development.

In the 12 months leading up to the end of Q1, **151 parents have been referred to PCI groups and 68% sustained their attendance at the group** by attending 4 or more of the 6 sessions. There was a notable increase in Q1 to 81% sustained attendance from 69% in Q4.

Parents are observed and assessed pre and post groups by the facilitator on the frequency of their use of the strategies taught such as; following the child's lead, commenting and repeating language. The chart on the left illustrates the **average group score pre and post groups rose from 11 pre PCI groups to 20 post PCI groups** demonstrating an increase in parents using strategies to encourage speech and language development during interactions with their children. Reasons for not sustaining intervention included; parents/family unavailable, family moved out of area, parent felt their child would not benefit and parents starting a new job.

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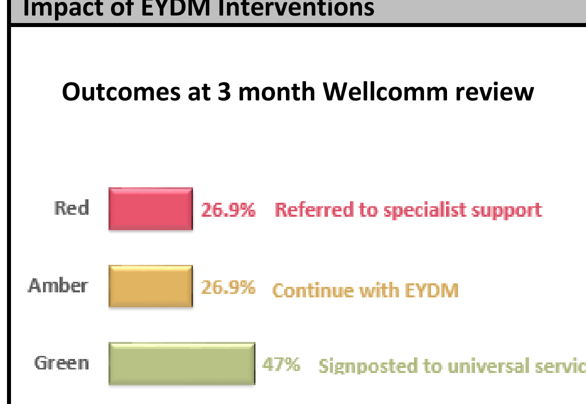
Impact of EYDM Interventions	
	The Wellcomm review takes place 3 months post intervention and assesses whether children score as red (requiring specialist support), amber (requiring targeted intervention from the EYDM) or green (universal support) post intervention. All children have previously been assessed as amber or red at referral Collecting review data commenced in April 2016. **To date 439 children are eligible for review and 67% have received a review**. Reasons for not undertaking the review are reported as: limited time available within the setting, therefore only focusing on reviewing children who they are concerned about and children leaving settings before the review period is complete. The chart on the left shows the outcomes of review assessments and illustrates **that 47% of children were assessed as green and therefore required universal provision only 3 month post intervention**. Following the review, children who continued to be assessed as having amber needs were offered further support from the EYDM Communication and Language Pathway. For some children the EYDM pathway uncovers a need for specialist services, these children are assessed as red at review and referred to the SaLT service, subject to a discussion with parents. **There has been a substantial increase in referrals to the SaLT specialist service in 2016 from 275 to 648**. The high referral rate has created a challenge for the specialist speech and language therapy service and waiting times for initial assessment has increased. Once assessed, the children and families will access appropriate advice and support.

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Children and Parents Service (CAPS)

CAPS is a multi-agency, early intervention service delivering high quality, evidence based interventions to Manchester's most vulnerable pre-schoolers and their families. All CAPS interventions are delivered to targeted families with clinically significant problems such as:

Poor attachment	Child behaviour/ conduct problems	Parental depression	Parental stress and anxiety	Parental lack of confidence	Risk of harm and neglect

There is overwhelming evidence that failing to tackle these problems early on in preschool leads to poorer life chances.

Incredible Years (IY) Parent Training Programme, Webster-Stratton (Parent Survival Courses in Manchester)

The Incredible Years Parent Programme is the gold standard intervention within its field. Incredible Years is a recommended intervention for children with behaviour problems, conduct disorder and ADHD. It has extensive empirical support for its effectiveness in:

- Reducing childhood behaviour problems
- Reducing parental depression
- Reducing parental stress and anxiety
- Reducing children's anti-social behaviour
- Improving children's self-regulation
- Improving parent-child interactions
- Improving parenting

Positive outcomes from early intervention for children with behaviour problems have been shown to be maintained 8–10 years later (Webster-Stratton, Rinaldi & Reid, 2001).

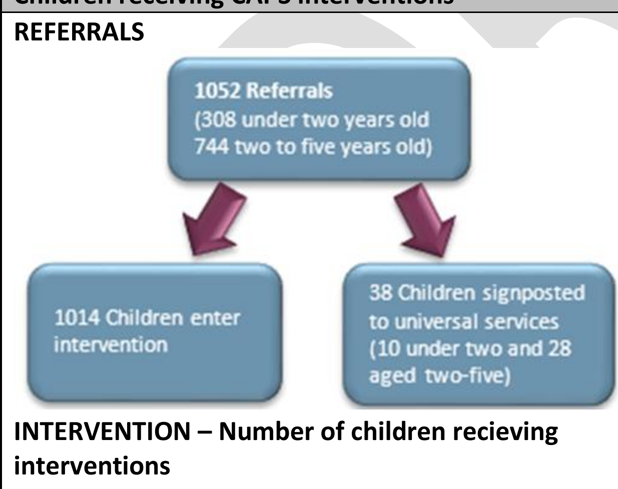
Video Interaction Guidance (VIG)

There is a strong and growing evidence base for the effectiveness of VIG as an intervention for change with families. Research suggests VIG is effective in:

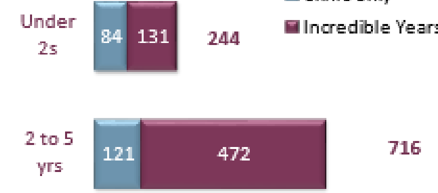
- Enhancing maternal sensitivity
- Reducing parental stress
- Improving child behaviour and cognitive functioning.

Children receiving CAPS interventions

REFERRALS



INTERVENTION – Number of children recieving interventions



Children and Parent Service (CAPS) are commissioned to deliver a suit of parenting interventions; these are divided into interventions for under 2 year olds such as IY baby and interventions for 2-5 year olds such as IY Pre-school. Children seen in clinic only receive VIG and/or CBT.

In the 12 month up to the end of Q1 **1052 under 5 year olds were referred to the service**. Of these referrals, 38 children did not meet the criteria for intervention and were signposted to universal services. The remaining **1014 children entered CAPS interventions.**

The target for CAPS is to reach 20% of the preschool population by 2018, this equated to approximately 7,800 children. To be in line to meet this target CAPS were expected to have reached at least 11% of the population by the end of the 2016/17 year. **By the end of Q1 CAPS have reached approximately 6,200 children including siblings, this equated to 16% of the population demonstrating they are in line to meet the 2018 target.**

CAPs delivered interventions to 244 children under 2 and 716 children aged 2-5 years. The majority of children attended IY courses, 603 children attended IY courses and 205 children

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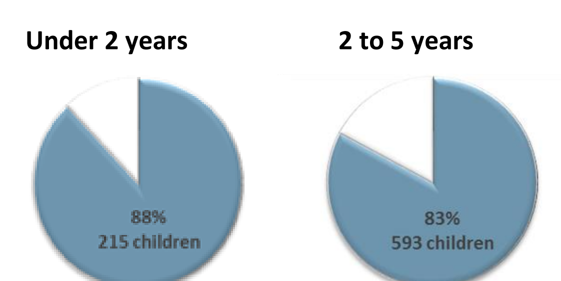
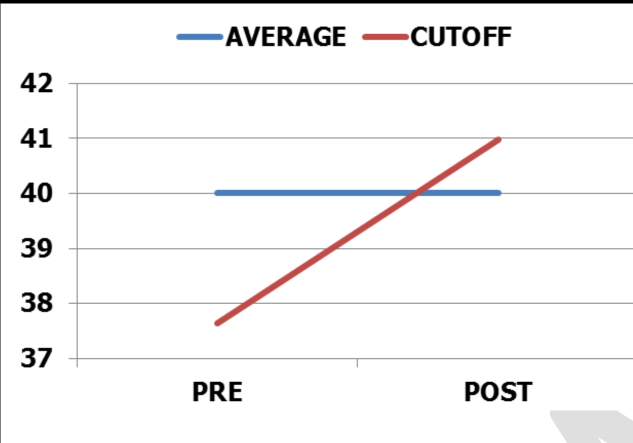
RETENTION - % of children completing intervention



were seen in clinic only.

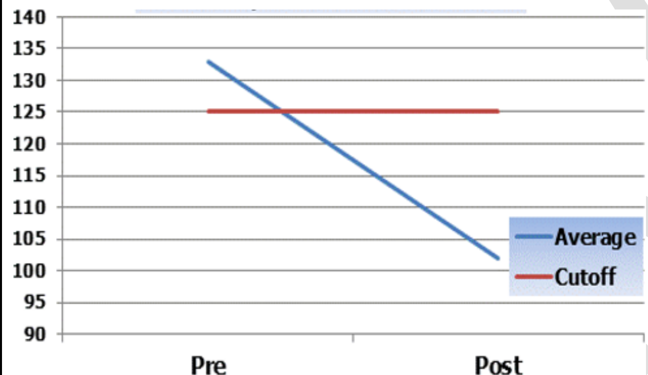
Retention rates for interventions are above 80%. For under 2 year olds retention on IY Baby was 87% and 89% at clinic, *data for Parent Survival courses is not yet available*. For children aged 2 to 5 years old retention was 82% for IY and 86% in clinic.

Impact on under 2 year olds - Karitane Parenting Confidence Scale (KPCS)



The Kartiane is completed by parents with children under 2, it is a self-report instrument used to measure parenting confidence which is clinically significant in outcomes for children. The more confidence a parent has the better the outcomes on children's behaviour and development. Scores below 40 meet the need for intervention; at the start of intervention the mean score for the group was 37.5, after intervention this increased to 41, demonstrating clinically significant improvement into normal ranges. This equates to **138 parents moving from in the clinical range for intervention before intervention to the non-clinical range post intervention.**

Impact on 2-5 year olds - Eyberg Child Behaviour Inventory (ECBI)

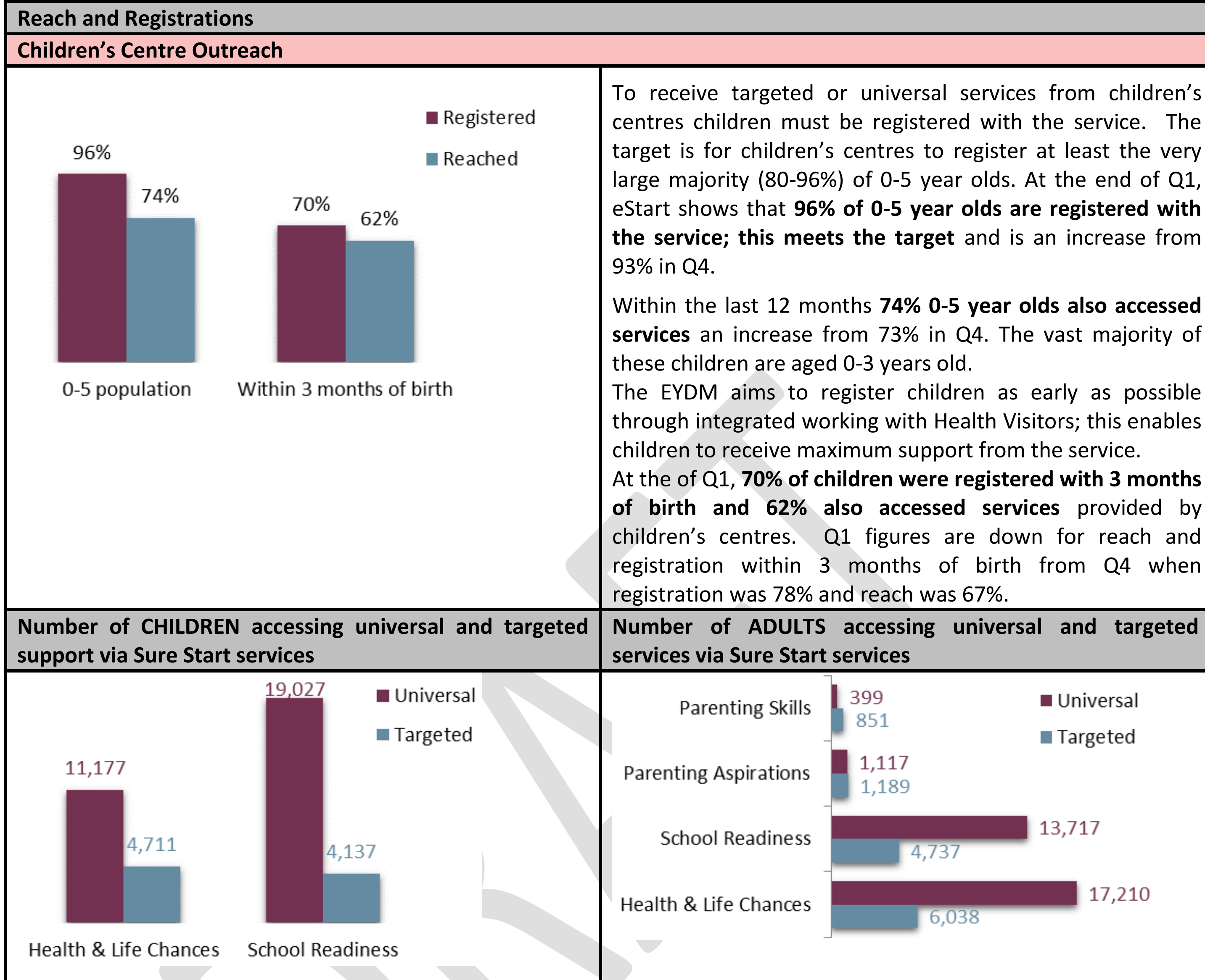


The ECBI is completed by parents with children aged 2 years and above, accessing the Parent Survival Course or Pre-School Psychology Clinic. It is a 36 item parent self-report instrument designed to assess conduct behavioural problems in children and adolescents by measuring the number of difficult behaviour problems and the frequency with which they occur. Scores above 126 meet the need for intervention, at the start of intervention the mean score was 133, after intervention this decreased to 102, demonstrating clinically significant improvement into normal ranges.

This equates to 392 parents **assessed as in the clinical range for intervention before intervention moving to the non-clinical range post intervention**. CAPs continually assess and work with children who remain in the clinical range. Parent comments on the impacts they experienced included;

> Now he's just a different child and his behaviour at school has changed. He's not been sent home from his new school for a whole year.

> I've seen the turnaround it's had on the girls. Their language and school readiness… from a few months ago… they're completely different children. They are more friendly with other children and with each other. We're singing a lot of nursery rhymes… they're recognising numbers and random colours.



To receive targeted or universal services from children's centres children must be registered with the service. The target is for children's centres to register at least the very large majority (80-96%) of 0-5 year olds. At the end of Q1, eStart shows that **96% of 0-5 year olds are registered with the service; this meets the target** and is an increase from 93% in Q4.

Within the last 12 months **74% 0-5 year olds also accessed services** an increase from 73% in Q4. The vast majority of these children are aged 0-3 years old.
The EYDM aims to register children as early as possible through integrated working with Health Visitors; this enables children to receive maximum support from the service.
At the of Q1, **70% of children were registered with 3 months of birth and 62% also accessed services** provided by children's centres. Q1 figures are down for reach and registration within 3 months of birth from Q4 when registration was 78% and reach was 67%.

Children's Centre services deliver both universal and targeted intervention to 0-5 year olds as part of the Children's Centre Core Purpose. Universal activities are open to all families living in the area whereas targeted activities are available to children and families identified by a range of partners and stakeholders including outreach workers, health colleagues, adult education, self-help organisations, voluntary sector and job centre plus, this may or may not be part of an EHA plan. Interventions for children relate to the health and life chances and school readiness elements of the Core Purpose whereas adult interventions relate to all elements of the Core Purpose.

The charts above indicate how many children and adults have received universal and targeted intervention for each of element of the Core Purpose in the 12 months up to the end of Q1. For children, more children received universal and targeted intervention for school readiness. In total **25,158 children received universal intervention and 8,370 targeted**, these figures may be less than the sum of health and life chances and school readiness figures in the chart as children could receive targeted or universal intervention under more than one Core Purpose.

For adults the most frequent universal and targeted adult interventions are activities under the health and life chances element of the Core Purpose. In total **25,521 adults accessed universal interventions and 10,118 accessed targeted interventions** in the 12 months up to the end of Q1. This may be less than the sum of adults accessing each element of the Core Purpose shown in the chart as adults can receive targeted or universal intervention under more than one Core Purpose heading.

Child Development and School Readiness: Stay, Play and Learn sessions

4,137 Children and 4,737 parents were targeted and attended a Child Development and School Readiness SSCC activity

between 1st July 2016 and 30tH June 2017. One of the main Child Development and School Readiness targeted activities for children and parents is Stay, Play and Learn. Planning for Stay, Play and Learn session's is linked to the EYFS three prime areas and activities are planned and differentiated for the different ages of children attending the session. Specific areas are focussed on observations, reflections and evaluations of present and previous sessions. Planning for the sessions always incorporates a home learning opportunity focus with resources provided. Feedback from Parents on the impact of sessions attended at recent Stay Play and Learn sessions taking place across the city include;

"The Stay and Play sessions have prepared my son for nursery. He has learned colours, numbers, songs and nursery rhymes"

"My child only had about 5 words a few months ago and no interest in interacting, now actively participates and enjoys talking to others"

I have noticed my son's behaviour is improving. He now shares toys, listens to a story and follows simple instructions

"My daughter is more confident and independent, attending the sessions has helped her to learn to take turns and share more"

Child Development and School Readiness activities: Manchester Adult Education Services (MAES)

Child Development and School Readiness activities are also provided for parents through working in partnership with Manchester Adult Education Services (MAES) who provide; Family English, Family Maths, Fun with Numbers, Ready for School, Starting School, Learning through play and Phonics and Literacy courses. Feedback from parents attending MAES courses include;

"I have now found unique ways to spend time with my child. I have learned lots of activities through the course like maths, counting, reading and a little bit of writing and which provides lots of fun with my child"

"It has given me a different aspect of learning, how to make it fun for the children rather than it to be serious and how easy it is to teach and engage them in learning"

"Has given me ideas for different activities to do at home including using real life objects rather than expensive toys"

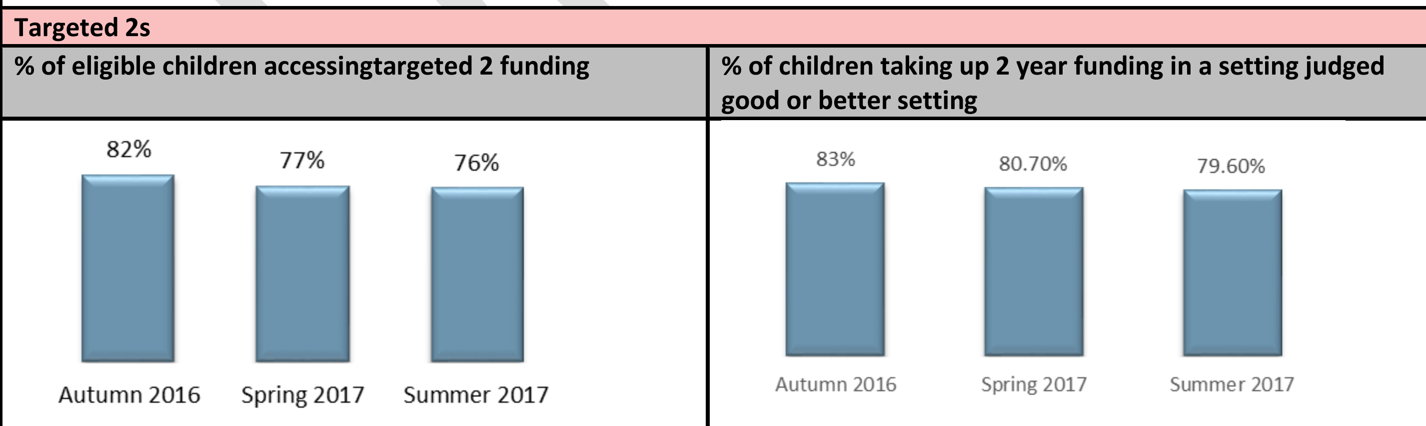
Parenting Aspirations and Self Esteem activities

1,189 parents were also targeted during this period and attended Parenting Aspirations and Self Esteem activities. The SSCC MAES partner also provides; ESOL including Talk English level 1 and 2, Confident Parent / Confident Child, Understanding Children's Behaviour, Literacy, Numeracy, Taking Control of Your Life course. Feedback from parents who attended recent ESOL courses in children centres across the city.

"After completing the ESOL I am now able to communicate in Basic English with my children and their teacher"
"I am more confident too to speak and write in English, I practice copying words"
"I know more English words and can talk to other parents"
"The course was very useful and one day I want to help others to learn"

Targeted 2s

% of eligible children accessingtargeted 2 funding	% of children taking up 2 year funding in a setting judged good or better setting



The chart on the left demonstrates the take up of Targeted 2 funding by children who are eligible from the Autumn 2016 to Summer 2017 term. Take up has decrease slightly from 77% in Spring to 76% in Summer, but remains higher than in Summer 2016 when take up was 67%. The DfE estimate that nationally 68% of children age 2 eligible for Government funding were benefiting in January 2016. In the Summer 2017 term 79.6% of children in a Target 2 funded place in Manchester are accessing funding in settings judged 'good' or 'outstanding' by Ofsted. Nationally, in January 2016, 84% of 2 year olds benefiting from some funded early education were at a setting rated good or outstanding.
A process for tracking the progress of children receiving target 2s is in development to measure impact.

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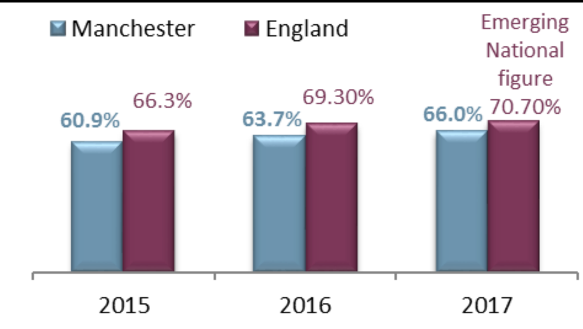
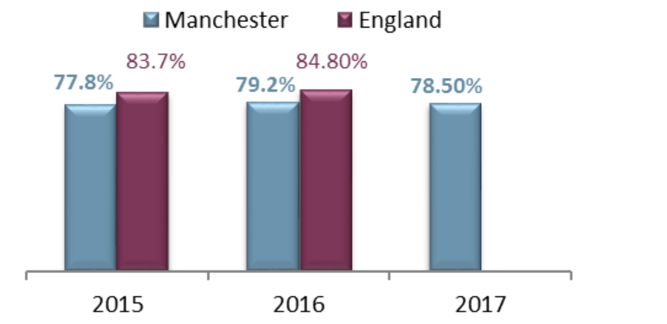
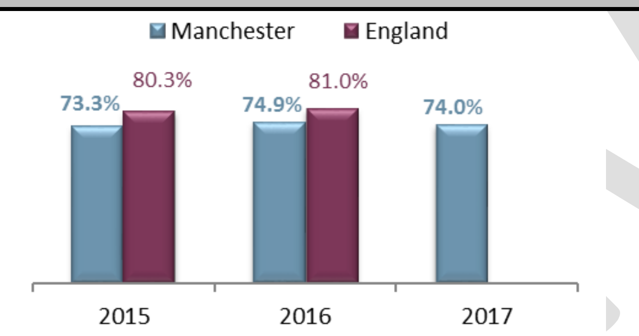
KPI Data	
Data in this section relates to the population outcomes that the EYDM aims to contribute towards. The KPIs are updated annually to place outcomes in the EYDM into the context of overall outcomes for the o-5 population.	
% of children reaching a good level of development at the end of EYFS	**% of children reaching a good level of development in PSE**
	
Results show 3 year trend data for children attending schools in Manchester. The target is to be at least in line with the national average. The official 2017 England statistic will not be available until November 2017, the emerging figure provides a good indication from data LAs have submitted before the DfE verification process.	Results show 3 year trend data for children attending schools in Manchester. The target is to be at least in line with the national average. Emerging national figures are not available for PSE, the national figure will be available in November 2017.
% of children reaching a good level of development C&L	
	
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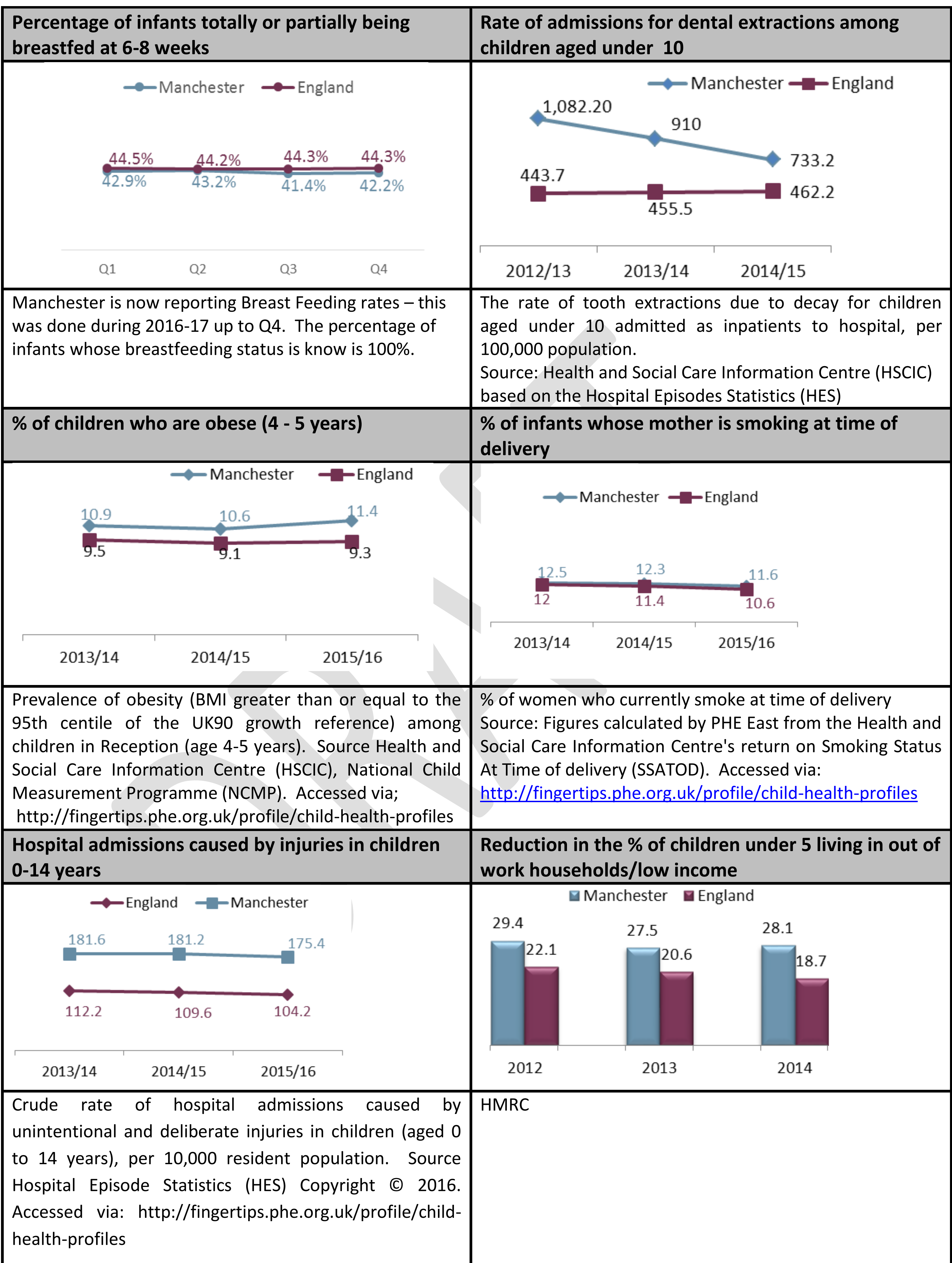

Percentage of infants totally or partially being breastfed at 6-8 weeks

Manchester is now reporting Breast Feeding rates – this was done during 2016-17 up to Q4. The percentage of infants whose breastfeeding status is know is 100%.

Rate of admissions for dental extractions among children aged under 10

The rate of tooth extractions due to decay for children aged under 10 admitted as inpatients to hospital, per 100,000 population.
Source: Health and Social Care Information Centre (HSCIC) based on the Hospital Episodes Statistics (HES)

% of children who are obese (4 - 5 years)

Prevalence of obesity (BMI greater than or equal to the 95th centile of the UK90 growth reference) among children in Reception (age 4-5 years). Source Health and Social Care Information Centre (HSCIC), National Child Measurement Programme (NCMP). Accessed via;
http://fingertips.phe.org.uk/profile/child-health-profiles

% of infants whose mother is smoking at time of delivery

% of women who currently smoke at time of delivery
Source: Figures calculated by PHE East from the Health and Social Care Information Centre's return on Smoking Status At Time of delivery (SSATOD). Accessed via:
http://fingertips.phe.org.uk/profile/child-health-profiles

Hospital admissions caused by injuries in children 0-14 years

Crude rate of hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 14 years), per 10,000 resident population. Source Hospital Episode Statistics (HES) Copyright © 2016. Accessed via: http://fingertips.phe.org.uk/profile/child-health-profiles

Reduction in the % of children under 5 living in out of work households/low income

HMRC

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